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ABSTRACT

A framework is given for providing comprehensive health education services within a Health Maintenance Organization (HMO) setting. In order to be effective, an HMO's health education program needs to be administrationally and organizationally approached as an integral component of the HMO and not as an adjunct service. Three service units of the health education program provide health education for scheduled subscribers, non-scheduled subscribers, and for scheduled homogeneous groups. Subscribers to the HMO, upon arriving for a scheduled medical appointment, are directed to the health education unit where they wait until called. Health educators, through multi-media and live programs, use this waiting time for health education. A similar service is offered to subscribers who have no immediate health care appointments. A health education unit also offers small group programs for subscribers with similar health or medical problems. These subscribers receive education programs targeted for their particular condition. (JD)

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A HEALTH EDUCATION CADRE FOR HEALTH MAINTENANCE ORGANIZATIONS

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Abstract

The Health Maintenance Organization Act directs Health Maintenance Organizations (HMO's) to provide health education services to its subscribers. A recent survey of HMO's indicates that HMO's may be replicating the identical errors public schools committed in the early 1960's when implementing their health education programs. These organizational threats to the efficacy of HMO health education programs are addressed. Furthermore, an organizational framework is suggested which is designed to provide comprehensive health education services within an HMO setting.

A Health Education Cadre for Health Maintenance Organizations

The Health Maintenance Organization Act of 1973 directs Health Maintenance Organizations (hereafter, HMO's) to provide health education services to its subscribers (Shapiro, 1975). The reasoning behind this directive is sound both in theory and outcome (Shapiro, 1975; Pigg, 1976; Caron & Roth, 1977; Kreuter, 1976). An examination of a recent survey of HMO's by Metropolitan Life Insurance Company (1979) suggests that HMO's might be replicating the identical errors public schools committed in the early 1960's when attempting to implement health education programs. For example, the survey indicated 86% of the responding HMO's employed two or fewer staff members committed to health education and 66% had one or fewer full time staff members. The survey also reported that administrative responsibility for HMO's health education programs were usually designated to a staff member whose expertise or professional training were not in health education. Thus, a medical director, staff nurse, or marketing director, in addition to their other responsibilities, was also responsible for the HMO's health education program. Finally, 50% of the HMO's did not actively evaluate their health education programs and 90% indicated a need for help in developing an educational strategy (Metropolitan Life Insurance Company, 1979).

The focal point of this paper is to identify several conditions which can undermine the efficacy of an HMO's health education program. In addition, an organizational framework will be suggested which is designed to provide comprehensive health education services within an HMO setting.

Insuring the Efficacy of Health Education

The health education program within the HMO requires several organizational constructs. Three such constructs are: administrative support, adequate resources, and professionally prepared health educators. The literature suggests if a parent organization is remiss in one of these key constructs, its health education program is adversely affected (Sliepcevich, 1964; Veenker, 1965).

Administrative support for an HMO's health education program is difficult to quantify or qualify. However, there are crude measures which shed some light on the committment an HMO has made toward its health education program. These measures can be expressed by the following questions.

1. What is the proportion of the subscriber population to full and part-time professionally prepared health educators?
2. Where does the health education service budget rank, when compared to all other service budgets within the HMO?
3. Is there a voting professionally trained health educator seated on the HMO's policy making committees? Or is the health education program represented by a surrogate on these committees?
4. How many man hours are expended by the health education staff in servicing subscribers and how many man hours are expended by the health education staff in justifying health education to the parent organization?

In essence the HMO needs to provide its health education program direct administrative representation and support. In order to be effective an HMO's health education program needs to be administrationally and organizationally approached as an integral component of the HMO and not as an adjunct service.

All programs require resources in capital, personnel, space, hardware, and software. Without adequate resources a health education program or any program cannot serve its clientele. One must appreciate the unique requirements of each health service. Each program requires tools which are essential for that program's effectiveness. An HMO health education program requires resources and tools which are not typical of the medical setting. Some examples of these resources are: central location within the HMO, electric and paper media budgets, and large space allocations. It is essential that the HMO is cognizant and supportive of the kinds of resources its health education program requires.

The HMO which draws solely upon secretaries, indigenous lay people, and college graduates, and then labels these people health educators makes two assumptions. The first is that through "maturation" these people will develop the knowlege, skills, experience, and dedication of a health educator (SOPHE, 1976; Bruess, 1976). In line with this, the HMO should keep in mind that the neo-health educator demonstrated an interest in health education at the point of the job interview, and not four or five years earlier as a result of a career choice. Therefore, the HMO must be prepared to risk a high job turnover rate and possible retardation of its health education program. The second assumption is based in part of the first. The HMO who hires a neo-health educator also assumes that indigenous professional staff are willing and qualified to act as mentors for the neo-health educator. However, medical professionals have been repeatedly criticized as being too expensive and sometimes poorly prepared to provide preventive health care (Fuchs, 1974; Somers, 1971). Clearly the emphasis of medical education is on diagnostic and treatment skills for students. In contrast,

health education requires a professional whose education emphasizes preventive skills in health.

Thus, the HMO which employs neo-health educators might not be qualified or equipped to professionally train such personnel. There are also some legal and ethical concerns HMO's need to address when employing neo-health educators. One such concern is, should HMO providers have jurisdiction over the qualifications, training and services of that person who is designated (by the provider) as the HMO health educator? Such practices might be viewed as institutional licensure.

Hence, three key constructs of an HMO's health eduation program are: the professionally prepared health educator (one who has earned at least a baccalaureate degree in health education from an accredited college or university), the allocation of adequate resources, and the administration's support. Without one or more of these three constructs, a health education program is seriously handicapped and becomes more of a financial burden, rather than an asset to its organization.

The next phase of constructing an HMO's health education program is the marrying of the health education unit into an HMO organizational model. Ideally such a model will organize the HMO's services in such a way that most, if not all, subscribers are exposed to the HMO's health education programs.

The Health Education Institute Within the HMO

The HMO concept offers a health care system where wellness rather than illness is emphasized (U.S. Dept. of Commerce, 1976). An HMO health education unit is striving to serve all subscribers while treatment (illness) units

ideally strive to serve relatively few subscribers. Therefore, there must be an appropriate organizational structure in the HMO to enhance the health education unit's ability to serve a maximum number of subscribers and subscriber subgroups. Such an organizational structure would expose subscribers to the HMO's health education services while they secure other services from the HMO.

Insert Diagram about here

The preceding paradiagram insures exposure of each subscriber who enters an HMO to one or more health education service. A possible exception is the subscriber who requires emergency medical service. This organizational scenario possesses several inherent advantages for the provider and the client. An explanation of the paradiagram and its provider and client advantages follow.

The health education cadre incorporates three service units and is directly linked to the Triage Unit.

Triage Unit. The role of the Triage Unit is to place immediately or ultimately scheduled and non-scheduled subscribers.

This unit contains the necessary admitting professionals and paraprofessionals and also a health education receptionist-typist. The health education receptionist's role is to place immediately or ultimately scheduled subscribers into one or more of the health education services.

The three service units of the health education program are: health education for scheduled patients, health education for non-scheduled patients, and health education for scheduled homogeneous groups.

Health Education for Scheduled Subscribers

This unit is the largest of the three health education units. First, the health education receptionist verifies the correctness of the subscriber's appointment card. Having done this, the health education receptionist assigns a number to the subscriber and directs the subscriber to the health education unit (preferably an auditorium) for scheduled subscribers.

Utilizing a bulletin board with cards, or similar mechanical or electronic device, the appointment numbers of subscribers at the appropriate time are portrayed, thus indicating to the subscriber it is time for him to proceed to the appropriate HMO service unit for treatment or care. However, while in the auditorium, the scheduled subscriber becomes the health educator's captive audience. Health educators through planned multi-media and live programs utilize the waiting time of the subscribers for health education. Health educators would plan and implement 10-20 minute continuous health education presentations in a variety of content areas. For example, some presentations might include:

1. Subscribers effective participation in the HMO.
2. Self-health care and its appropriateness (Canfield, 1974).
3. Preparation for and articulation during the physicians visit (Canfield, 1974).
4. Subscribers expectations and physician abilities.
5. Subscriber need surveys.
6. Early detection of illness.
7. Evaluation of HMO's services by the subscriber.
8. Presentations and orientations to new or revised services in the HMO.

The scope and the content of the health education presentation are as finite as subscriber's health and medical care needs. Within this scenario it is possible to survey each subscriber who utilizes an HMO service. Such surveys could provide the HMO with a wealth of useful data.

Health Education for Non-Scheduled Subscribers

This unit is designed for the subscriber who has no immediate health care appointments. Each and every subscriber may utilize this service on a walk-in basis. This unit would present multi-media and live health education programs lasting between 30-50 minutes. The programs would be announced in advance and advertised. Programs would be scheduled at times during the week which are convenient to the subscriber population. Examples of such programs might include:

1. More detailed presentations of the programs offered for scheduled subscribers.
2. Presentations on well care.
3. Presentations on life style and pathogenesis (Fuchs, 1974).
4. Question and answer sessions with indigenous and non indigenous practitioners.
5. Nutritional requirements of the elderly.
6. Presentations on the practice and philosophy of health and health maintenance.
7. Presentations on stress and stress indicators.
8. Updates on new or recently banned legend and over-the-counter drugs.
9. Presentations on the psychological and physiological manifestations of chemical dependence.
10. The synergistic effects of legend, over-the-counter, and social drugs.

Once again, the types of presentations and the opportunity for program and service evaluation is limited only to the health educator's creativity, competencies, and command of resources.

Health Education for Scheduled Homogeneous Groups

This unit services subscribers with similar health or medical maladies. The subscriber is identified by the HMO; family physician, surgeon, psychologist, etc. as one who would benefit from a small group (5-20) health education program, targeted for their particular malady or condition. These small group health education programs would last 30-50 minutes and be scheduled at times during the week convenient to the subscriber population. Such health education programs might include some of the following:

1. Post operative adaptation and personal care (i.e., Mastectomy, abortion, cardiac care, hysterectomy).
2. Programs for subscribers with somatic complaints without identifiable cause.
3. Presentations for subscribers with chronic or terminal conditions (i.e., acne, allergy, diabetes, cancer).

This unit can also be utilized by the HMO for inservice programs for its professional and paraprofessional staff. Examples of such programs are:

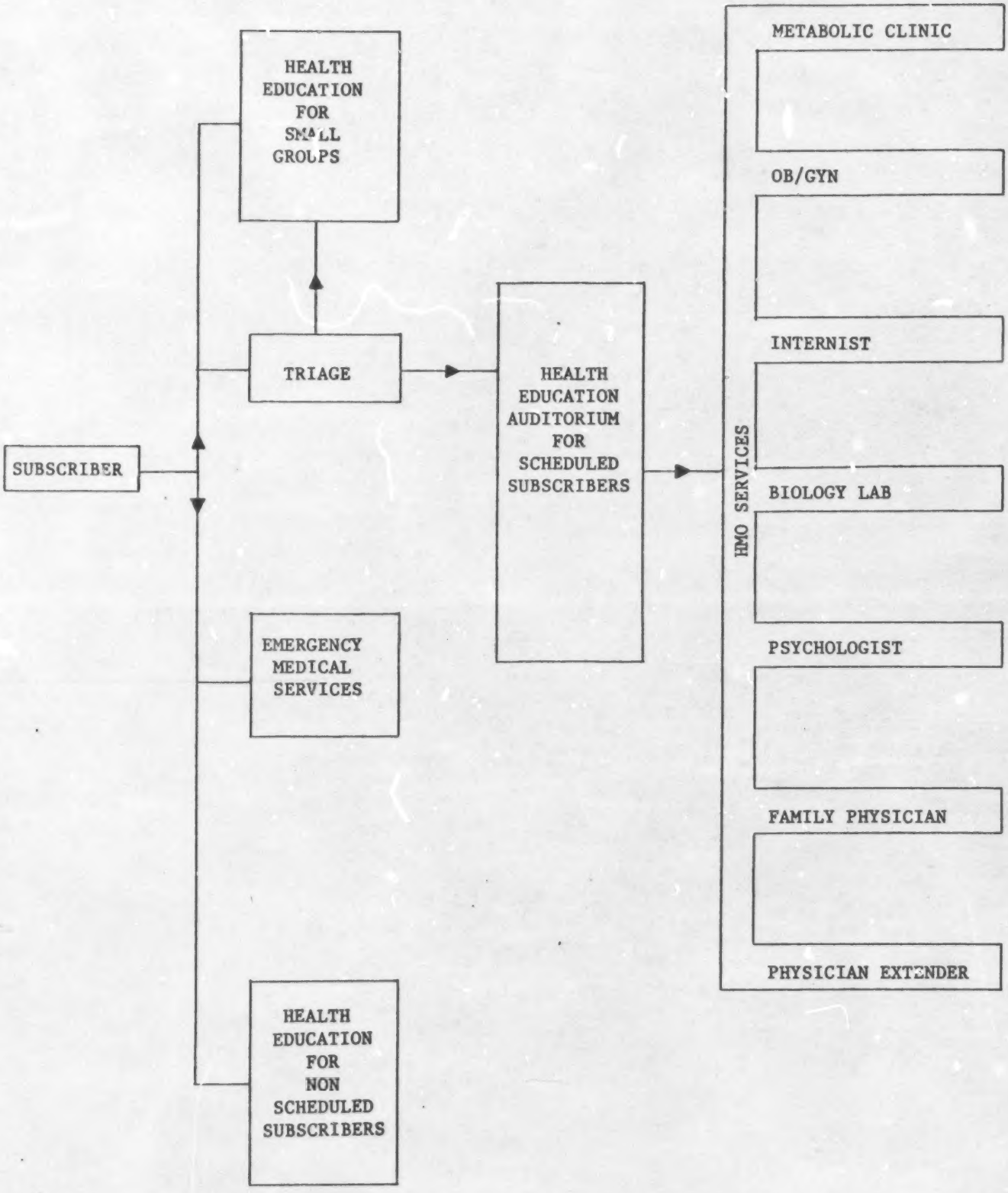
1. Physicians directions to subscribers.
2. The examination and treatment of the retarded or the uncooperative subscriber.
3. Psychological management of the organically ill patient and their families.

Epilogue

One intent of the Health Maintenance Organization Act (PL. 93-222) is to reduce treatment care by increasing preventive care via health education. This goal is attractive in that it serves society's humanitarian needs and is economically preferable. A society who is informed and up to date on health matters is a goal shared by PL 93-222, the health education profession, and the nation.

One way HMOs can fulfill their obligation to PL. 93-222 and society is to expose their populations to comprehensive health education services. Anything less would be an abrogation of the HMO mandate.

AN HMO ORGANIZATIONAL MODEL FEATURING COMPREHENSIVE HEALTH EDUCATION SERVICES



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